DR.
RUTH
ROJAS
Prosthodontics
& Cosmetic Dentistry

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Monday - Thursday
7:30 am - 4:00 pm

REFERRAL FORM

From Dr. ______________________ Phone ______________________

Patient ______________________ Phone ______________________

Appointment Date: _____ • _____ • _____ Time: _____ : _____ am • pm

Patient is referred for:

- ☐ IV Sedation
- ☐ Nitrous Oxide Analgesia
- ☐ Specialized Local Anesthesia Techniques

Dental concerns:

- ☐ Full Edentulous Arch ☐ Partial Edentulous Arch
- ☐ Full mouth rehabilitation
- ☐ Esthetic/Occlusion
- ☐ Sleep Apnea

Special medical concerns:

Additional comments about dental conditions: